CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE BURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: . . COMPLETED A. BUILDING B. WING 188250 11/24/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1100 GRANDVIEW DRIVE, P O BOX 822 **OAKMONT MANOR** FLATWOODS, KY 41139 PROVIDER'S PLAN OF CORRECTION . (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID PREFIX (XS) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) INITIAL COMMENTS F 000 F 000 Oakmont Manor does not believe and does not admit that any An Abbreviated Survey investigating ARO deficiencies existed, either before. KY00015616 was initiated on 11/22/2010 and during or after the survey. Oakmont concluded on 11/24/2010. ARO KY00015616 Manor reserves all rights to contest was substantiated, and deficiencies cited with the the survey findings through informal highest S/S being a 'G'. dispute resolution, formal legal F 167 F 157 483.10(b)(11) NOTIFY OF CHANGES appeal proceedings, or any (INJURY/DECLINE/ROOM, ETC) SS≃G administrative or legal proceedings. A facility must immediately inform the resident; This plan of correction does not consult with the resident's physician; and if constitute an admission regarding known, notify the resident's legal representative any facts or circumstances or an interested family member when there is an surrounding any alleged deficiencies accident involving the resident which results in to which it responds, nor is meant injury and has the potential for requiring physician to establish any standard of care, intervention; a significant change in the resident's contract obligation or position. physical, mental, or psychosocial status (i.e., a Oakmont Manor reserves all rights deterioration in health, mental, or psychosocial status in either life threatening conditions or to raise all possible contentions and clinical complications); a need to alter treatment defenses in any type to civil or significantly (i.e., a need to discontinue an criminal claim, action, or existing form of treatment due to adverse proceeding. Nothing contained in consequences, or to commence a new form of this plan of correction should be treatment); or a decision to transfer or discharge considered as a waiver or any the resident from the facility as specified in potentially applicable peer review, §483.12(a). quality assurance or self-critical The facility must also promptly notify the resident examination privileges which and, if known, the resident's legal representative Oakmont Manor does not waive, or interested family member when there is a and reserves the right to assert in change in room or roommate assignment as claim, action or proceeding. specified in §483.15(e)(2); or a change in resident rights under Federal or State law or 4 Oakmong Manor offers its regulations as specified in paragraph (b)(1) of responses/credible allegations of this section. compliance and plan of correction as part of its ongoing efforts to The facility must record and periodically update the address and phone number of the resident's provide quality of care to our legal representative or interested family member. residents. LABORATORY DIRECTOR'S OR PROVIDENSUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any deficiency platement ending with an esteriek (?) denotes a deficiency which the institution may be excused from correcting providing it is determined that other extended provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

1.1011

DEPARTMENT OF HEALTH AND HUMAN DERVICED

00TED.F. 20/2010

FORM APPROVED

Jan. 7. 2011 4:28PM Oakmont Manor

No. 7621 P. 2

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/10/2010 FORM APPROVED OMB NO. 0938-0391

		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
1	•	A. BUILDING	·	c	
	185250	B. WING		11/24/2010	
NAME OF PROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CODE 00 GRANDVIEW DRIVE, P O BOX 822	<u>.</u>	
OAKMONT MANOR	ì	•	LATWOODS, KY 41139		
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)		DATE OMPLETION, (X6)
by: Based on interview and determined the facility of physician was notified of two (2) of nine (9) samples adequate bowel eliminate facility's bowel protocol four (4) to twenty (20) of documented evidence of Protocol was implement notification of the resident failed to have of Although Interview and Resident #1 did not have movements, there was physician was notified it lack of bowel movement admitted to the hospital diagnoses including compaction. The findings include: Review of the facility's (BCP), which was not of must have at least one medium bowel movement to be considered adequal formulation bowel moved elimination bowel moved elimination bowel moved.	Is not met as evidenced I record review, it was lailed to ensure the of a change in status for pled residents (Residents #1 and #3 did not have ation, as defined by the I, for periods ranging from lays. There was no the facility's Bowel Care ned, including the ent's physician when the bowel movements. record review revealed we regular bowel no evidence the resident's reparding the resident's reparding the resident's ints. Resident #1 was I on 10/16/10, with natipation and fecal Bowel Care Protocol dated, revealed a resident (1) large or two (2) ents every three (3) days	F 157	It is and was on the day of such the policy of Oakmont Mano immediately inform resident's physician and if known, notifiegal representative of a neer alter treatment significantly. 1. Resident #1 no longer reseat Oakmont Manor. Resident physician has been notified of elimination pattern and treat plan is in place. Completed of November 29, 2010 by Unit Coordinator. 2. All residents bowel elimination has achieved and physician was not any issues identified. This completed on November 29 unit coordinator and reviewed QA nurse and DON. As of November 29th, The Quantum Assurance nurse and Director Nursing review all daily shift and physician's orders to ensure resident's physician has been of any need to alter treatments ignificantly.	y the d to ides it #3's of bowei tment in ation ensure s been notified was by the ed by uality r of reports ure the n notified	

		AND HUMAN SERVICES .			,		12/10/2010 APPROVED	
STATEMENT	AS FOR MEDICARE OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XX) M	ULTIF	PLE CONSTRUCTION	OMB NO. 0938-0391 (X8) DATE SURVEY		
, ,	·		A BUI	TDIN(G	COMPLETED		
	4	165250	B. WIN	IG		C 11/24/2010		
	ROVIDER OR SUPPLIER'			11	EET AODRESS, CITY, STATE, ZIP CODE 100 GRANDVIEW DRIVE; P O BOX 822 LATWOODS, KY 41139			
(X4) ID PRÉFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS REFERENCED TO THE APPL DEPICIENCY)	ULD 8E	(X6) COMPLETION DATE	
F 157	1. Milk of Magner results in 24 hours, 2. Dulcolax Suppresults in 12 hours, 3. Fleets Enema, 4. If no results, or Fleets Enema, 10002, if still inadequate Review of the facility Condition or Status was to be notified or condition and/or statistical facility of the cilination of the	sia (M.O.M.) 30 ml po, if no opsitory 10 mg rectally, if no inadequate results, with make means a results, notify Physician. Y's Changes in a Resident's Policy revealed the Physician f changes in the resident's itus. Inical record revealed imitted with diagnoses which Hypertension, Peripheral Coronary Artery Disease, and ire requiring Hemodialysis. Information Tracking Logs October of 2010 revealed no ce Resident #1 had a bowel leven (11) day period between 10. Continued review	F1	157	3. An in-service was conduct December 6th, by the Director Nursing for all licensed nursing reviewing physician notification requirements. 4. As part of the facility's one Quality Assurance Program to Director of Nursing and/or the Quality Assurance nurse will bowel elimination records downling review all MD orders and reports to ensure any significance in needs of resident are ported to the MD. The results of the audit will be reviewed by the Quality Assurance Committee on a monthly basis for six months to determine compliance.	or of ng staff on oing ne ne review aily and I shift cant	er 7, 2010	
	movement on 10/07	nt had a medium bowel 7/10, a small bowel movement small bowel movement on	·	Ì		December		
	Resident #1's bowe did not have an ade twenty (20) days, for Continued review re	cility's bowel protocol to ! record revealed the resident quate bowel movement for om 09/24/10 to 10/14/10. Evealed no evidence the was notified of the resident's ments.		•				

Jan. 4. ZVII I: IDENI DAKMONI MANOR

PRINTED: 12/10/2010

		AND HUMAN SERVICES & MEDICAID SERVICES		•		•	FORM	APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(XI) PROVIDENGUPPLIENCLIA IDENTIFICATION NUMBER:	A BUILDI		CONSTRUCTION		(X8) DATE B	URVEY
•		185250	B. WING			.		4/2010
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, ST	•		
OAKMON	T MANOR				Brandview Driv WOODS, KY 41	•	2 ·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	id Prefix Tag	·	(EACH CORRECT	PLAN OF CORRE TIVE ACTION SH CEO TO THE APP EFICIENCY)	QULD BE	(X8) COMPLETION DATE
F 157	Continued From pa	ge 3	F 157	7	,			
	at 4:45 PM revealed from the facility rela	ttending physician on 11/24/10 of the had never received a call sted to the resident's of bowel movements.						
	1:00 AM, and signed #1, revealed Residu constipation and reshift. Continued rethe nurse he/she was Lactulose did not was for the remainder of indication of the reshoot with the photostalion of the photostalion and respectively.	e's Notes dated 10/06/10 at d by Registered Nurse (RN) ent #1 complained of ceived Lactulose earlier in the view revealed the resident told ould need an enema if the ork. Review of Nurse's Notes if the shift revealed no cults following the Lactulose, ysician was notified, and no being offered to the resident.	,			•		
	11/24/10 at 3:45 PM Resident #1 compliconstipation and no stated she called the give an enema, who administer. The RI refused the enema wouldn't help anywerevealed RN #1 recipioerine supposite table. She stated at the medication carl would obtain a physiconstipation of the stated of the medication carl	stered Nurse (RN) #1 on A revealed she recalled ained, "one night" of seded an enema. The nurse is doctor, who said she could ich she attempted to N explained the resident and said, "I don't want it, it ay." Continued interview sailed finding a container of wries on the resident's bedside the locked the medication in and advised the resident she sician's order for the did not call the physician to						
	5:00 PM revealed I "pain in stomach, in chills." Continued	e's Notes dated 10/16/10 at Resident #1 complained of ust not feeling well, nausea, review revealed the resident of 101.1 degrees Farenhelt						

PRINTED: 12/10/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO: 0936-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X3) DÂTE SURVEY STATEMENT OF DEFICIENCIES . (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 6. WING 185250 11/24/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1100 GRANDVIEW DRIVE, P Q BOX 822 **OAKMONT MANOR** FLATWOODS, KY 41189 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (XE) ID (X4) ID PREFIX LEACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY F 157 F 157 Continued From page 4 and the spouse requested the resident be sent to the hospital. Further review of the Nurse's Notes revealed the resident was sent to the hospital, by ambulance, at 5:15 PM. Further review revealed a call was received from the hospital at 11:30 PM, informing the facility the resident had been admitted with abdominal pain and constipation. During interview, on 11/23/10 at 9:30 AM. Resident #1 reported a long history of constination which required the use of five (5) to six (θ) Colace tablets (a stool softener) twice a day. The resident reported the use of a "Fleets" suppository "at least twice a week." Further interview revealed Resident #1 reported he/she "begged them every day" to get an order for a "Fleets" suppository. The resident stated different nurses said they would contact the doctor for an order, but the resident did not believe they did because no suppositories were ever administered. The resident stated, "I begged them, they ignored me. They let me lay there and almost die. If it wasn't for my (spouse), i would have died. Now here I lie." Interview with the spouse of Resident #1 on . 11/23/10 at 2:30 PM revealed Resident #1 was admitted to the hospital on 10/16/10.. Continued interview revealed the spouse had spoken to the resident's surgeon after Resident #1 underwent surgery on 10/21/10. The spouse reported being

told by the surgeon the resident's bowel had burst. In addition, the spouse stated he/she was told the resident was so impacted, the bowel was dead and the resident required placement of a colostomy. Further interview revealed the spouse had spoken to the resident's attending physician, who had cared for the resident at the nursing home, and the physician reported he had never

Uakmont Manor PRINTED: 12/10/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES <u>OMB NO, 0938-0391</u> STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING 185250 11/24/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1100 GRANDVIEW DRIVE, P O BOX 822 **OAKMONT MANOR** FLATWOODS, KY 41139 SUMMARY STATEMENT OF DEFIDIENCIES (EACH DEFIDIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSO IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PRÉFIX PAEFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY F 157 Continued From page 5 F 157 been called by facility staff about the resident's lack of a bowel movement. The spouse further stated different nurses at the facility said they would call the doctor, but they never did. During interview on 11/24/10 at 4:45 PM, the attending physician for Resident #1 stated he had spoken to the surgeon, who reported the resident had a fecal impaction on admission to the hospital, with perforation of the bowel after admission to the hospital requiring surgical Intervention. 2. Review of Resident #3's clinical record revealed an admission date of 05/18/09 with diagnoses which included Dementia with Delusions and Constination. Review of the August-November 2010 Monthly Physicians Orders revealed an order for Lactulose (laxative) 30 milliliters (ml) by mouth once daily as needed due to constitution and an order for Bisacodyl (Dulcolax) 10 milligrams (mg) suppository rectally once daily as needed for constipation. Review of the August 2010 Bowel Information Tracking Log revealed no documented evidence of a BM from August 29-31 (3 days).

Review of the September, October and

November 2010 Bowel Information Tracking Logs revealed no documented evidence of adequate BMs, as defined by the facility's bowel protocol, from September 15-October 2 (18 days), October 8-17 (10 days), and October 19-22 (4 days). Further review revealed no documented evidence of adequate BMs from October 26-November 5 (11 days) and November 8-23 (16 days).

dan, 4. ZVII I. IIII dakiiidii maildi

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/10/2010 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:		(X2) M A. BUI		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
•	. •	185250	B. WIN			C 11/24/2010		
	PROVIDER OR SUPPLIER	•		11	EET ADDRESS, CITY, STATE, ZIP CODE 100 GRANDVIEW DRIVE, P O BOX 8 LATWOODS, KY 41139	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LBO IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORP (EACH CORRECTIVE ACTION 9 CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE ' '	OOMPLETION DATE	
F 157	Continued From p	age 6	F	157		•		
	Notes revealed no Physician was noti	ust-November 2010 Nurses documented evidence that the fied of the resident's condition g bowel elimination.						
	Practical Nurse #1 Protocol was not fi have received Lac enema several tim to find documentat of the change in bi 483.25 PROVIDE HIGHEST WELL Each resident mus provide the necess or maintain the hig mental, and psych	CARE/SERVICES FOR	F:	309	It is and was on the day of the policy of Oakmont M provide the necessary ca services to attain or main highest practicable physi mental, and psychosocial being in accordance with comprehensive assessme plan of care.	anor to re and stain the cal, well- the		
	by: Based on Intervieu determined the far care and services physical well-being sampled residents #7) Resident #1 elimination, per far days. As a result, the hospital with a	ENT is not met as evidenced wand record review it was clity falled to ensure necessary were provided for the residents' gs for four (4) of nine (9) a (Residents #1, #3, #4, and did not have adequate bowel clity protocol, for twenty (20) Resident #1 was admitted to severe fecal impaction. During the resident suffered a with sepsis, and required lostomy.	•		1. Resident #1 no longer at Oakmont Manor. Resident #4, and #7 have a routine pattern established. This completed on November the Unit Coordinator. 2. All resident's bowel flot have been reviewed to eacceptable bowel pattern reviewed by the QA nurs November 29, 2010.	dents #3, e bowel was 29 th by ow sheets nsure an n. This was		

Jan	. 4. 2011 1:17	rrivi Oakmont Iviaņor			. NO.	./400 F	. 12
		AND HUMAN SERVICES & MEDICAID SERVICES		•		FORM.	12/10/2010 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES FOORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(202) N		LE CONSTRUCTION .	(X3) DATE SURVEY COMPLETED	
		185250	B. WII	NG		1.) 1/2010
NAME OF P	ROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·			eet address, city, state, zip code		3,1
OAKMON	IT MANOR				ido Grandview Drive, p o 80x 822 LATWOODS, KY 41189		
(X4) ID PREFIX TAG	· (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SO IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS REFERENCED TO THE APPI DEFICIENCY)	OULD SE	(XS) GOMPLETION DATE
F 309	Continued From pa	ge 7	F	309		•	
	-	and the statement of the statement is			3. Daily the charge nurse will		
		mented evidence Resident #3, ced bowel movements for	•	.	review the bowel sheets and		
		m four (4) to eighteen (18)			implement the bowel progra		·
	days. There was n	o documented evidence the			for any resident who has not		·
,		Bowel Care Protocol regarding of medications and notification	4		had an adequate bowel mov	/ement	
		residente who did not have		· .	in three days.		
	regular bowel move				An in-service was conducted		
,	Who a should am a house of			- 1	by the Director of Nursing fo licensed staff on December :		. 1
· .	The findings include	P :			review the Bowel Protocol.	130,00	
į į	Review of the facility	ly's Bowel Care Protocol		.	•	!_	·
	(BCP), which was r	not dated, revealed a resident	•		4. As part of the facility's or		
		one (1) large or two (2)			Quality Assurance Program QA nurse will monitor the b	tue tue	
	to be considered at	vements every three (3) days, lequate. According to the			Sheets every Monday and Ti		
	facility's Bowel Car	e Protocol, if a resident has			· ·		
	gone three (3) days	without adequate bowel			for a period of six months to		,
		ge or two medium bowel rse should implement			ensure all residents are havi	ng	
	treatment as follow			,	bowel movements at least		i ' i
	1. Milk of Magne	sia 30 milliliters (ml) by mouth			every three days.	•	
;		its in 24 hours, 2. Dulcolax			Results of the aforemention	ad :	
		igrams (mg) rectally, and if no 3. Fleets Enema. 4. If no			Results of the aforemention audits will be reviewed by	GU	! !
,		ate results, with Fisets Enema,			Quality Assurance Committe	36	
•		enema x 2, and if still			monthly for six months to		
	inadequate results,	notify Physician.			determine compliance.	•	1
	_				· actermine compilation		.
		tent #1's closed record sion date of 09/24/10 and	,			Decemb	er 2, 2010
	dlagnoses which in	cluded Diabetes, Coronary					i 'l
		d Chronic Renal Failure, which			,	•	[' '
	required Hemodial	/SIS.			1		.
		ission Minimum Data Set t dated 10/06/10, revealed the		i			

		PRINTED: 12/10/2010 FORM APPROVED OMB NO. 0938-0391
1		(X8) DATE SURVEY COMPLETED
B. WING		C 11/24/2010
		22
ID PREFIX TAG	(EACH CORRECTIVE ACTION S	HOULD BE COMPLETION
F 309		
	A. BUILDING B. WING STA 11 F ID PREFIX TAG	STREET ADDRESS, CITY, STATE, ZIP'CODE 1100 GRANDVIEW DRIVE, P'O BOX 6 FLATWOODS, KY 41139 ID PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) F 309

		AND HUMAN SERVICES & MEDICAID SERVICES		PRINTED: 12/10/2010 FORM APPROVED OMB NO. 0938-0391
TATEMENT	OF DEFICIENCIES . OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	LTIPLE CONSTRUCTION (X9) DATE BURVEY COMPLETED C
		185250	B. WING	
	ROVIDER OR SUPPLIER		ŀ	BTREET ADDRESS, CITY, STATE, ZIP CODE 1100 GRANDVIEW DRIVE, P O BOX 322 FLATWOODS, KY 41139
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL BO IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (XS)
F 309	large bowel mover the log, Resident # bowel movement for 09/24/10 to 10/14/policy. Review of the Med (MAR) revealed the administered Lactuneeded for constipated the Lactulose every diand Senokot at be constipation. Furting documented evided the residual the residual evided the country of the MAR reveal Lactulose every diand Senokot at be constipation. Furting documented evided throughout the residual evided the lacture evided the lacture throughout the residual evided throughout throughout throughout throughout throughout the residual evided throughout	dent was noted to have had a nent on 10/14/10. According to it failed to have an adequate or twenty (20) days, from 10, as identified by the facility's lication Administration Record e resident could be alose (laxative) every day, as ation, however the resident lose on 10/05/10 at 11:45 AM, 00 PM only. Continued reviewed the resident could be given ay as needed for constipation, dilme as needed for her review revealed there was vidence the Senokot was given ident's stay; and there was no ince a Dulcolax suppository, a ra soap suds enema were ever	f 30	
	1:00 AM, and sign #1, revealed Residual	ses Notes dated 10/06/10 at led by Registered Nurse (RN) dent #1 complained of eceived Lactulose earlier in the eview revealed the resident told na may be needed if the ork. Review of subsequent the shift and for the following further reference to the int, results following that ministration of an enema, or physician regarding the adequate bowel movements.		
		#1 on 11/24/10 at 3:45 PM		

Vakillont Manor

STÄTEMEN	ERS FOR MEDICAR IT OF DEFICIENCIES OF CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	•	CONSTRUCTION	OMB NO. 0938-0391 (XS) DATÉ SURVEY COMPLETED		
. •		185250	B. WING	3		C 11/24/2010		
(PROVIDER OR SUPPLIER		,		,			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY PULL LSC IDENTIFYING INFORMATION)	ID PREFO TAG	٠	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO DROSS-REPERBNOED TO THE APP DEFICIENCY)	DULD BE	(ax) COMPLETION DATE	
F 309	"one night" of con The nurse stated she could give an attempted to adm resident, who the want it, it wouldn' she told the resid order for the supp she did not call the it along in report. Resident #1 ever during the residen	stipation and needed an enema. she called the doctor, who said enema. She further stated she inister the enema to the n refused it by saying "I don't help anyway." RN #1 stated ent she would get a physician's positories. She further stated e physician herself, but passed RN #1 was unable to recall having a bowel movement, nt's stay at the facility.	F 3	09				
	#2 on 11/24/10 at 11/24/10 at 10:10 provided care to Resident #1 volci constipated. Neit	rtifled Nursing Assistant (CNA) 19:40 AM and CNA #1 on AM, revealed they had this resident but could not recall ing concerns related to being her of the CNAs could recall the bowel movement during his/her						
	Prectical Nurse (this resident, revident #1 had constipation or n	24/10 at 12:40 PM with Licensed LPN) #1, who provided care to ealed she did not recall if any complaints related to ot having a bowel movement. I she did not recall the resident pository.						
	Manager (UM), v	14/10 at 4:55 PM, with the Unit where Resident #1 resided, wel Protocol should be initiated	,		`			

for any resident who did not have a bowel

movement in three (3) days. She stated the administration of PRN (as needed) medications should be documented on the MAR. The UM

explained she reviewed the bowel logs three (3) times a week but had not identified a problem

	, 4, ZVII 1:10	IN Cakillont Manor				14.0	. /400 r	. 10
		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	12/10/2010 APPROVED 0938-0391
BTATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/OLIA IDENTIFICATION NUMBER:	1' '	ULTIP LOING	LE CONSTRUCTION	·.	(X3) DATE BY	JRVEY .
		185250	B. WI	v g		C 11/24/2010		
NAME OF F	PROVIDER OR SUPPLIER			STÁE	ET ADDRESS, CITY,	STATE, ZIP CODE	·	
ОАКМО	NT MANOR	,			00 GRANDVIEW DF .ATWOODS, KY	•	2	·
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL MUST BE PRECEDED BY FULL	ID PREF TAG		· (EACH COARI	'S PLAN OF CORRI ECTIVE ACTION SI ENCED TO THE AP DEFICIENCY)	OULD BE	(X6) COMPLETION DATE
F 309	Continued From pa	ge 11	F	309	,	• • •		
	with Resident #1, o		•	·			•	
	movements. After	reviewing the Bowel Tracking h the surveyor, the Unit		٠				
		d surprise the resident had	•	ĺ	•		. •	* * * * * * * * * * * * * * * * * * * *
ì	gone so long withou	ut a documented bowel				•	•	
		rther stated she did not recall is also asking is					i	
	for an order for a si				•	•	•	
,	dated 10/07/10 reviews exercises Resident abdominal pain from Interview with the T	loal Therapy Progress Report ealed after therapeutic #1 "began to cry with m lack of bowel movement." herapy Assistant on 11/24/10				:		
	twice. She recalled really constipated a killing me, I'm cons interview on 11/24/	ed she only saw Resident #1- if the resident said she was and stated, "my stomach is tipated." During a follow-up if at 4:00 PM, the Therapy e did not recall reporting the atts to nursing staff.		-			•	
	5:00 PM revealed if "pain in stomach, it chills." Continued had a temperature The spouse request hospital. The Nurs resident was sent that 5:15 PM. The Nurs at 5:15 PM.	e's Notes dated 10/16/10, at Resident #1 complained of ust not feeling well, nausea, review revealed the resident of 101.1 degrees Farenneit, sted the resident be sent to the es's Notes revealed the the hospital, by ambulance, lote indicated a call was nospital at 11:30 PM, informing						
	the facility the residence abdominal pain and Review of the hosp #1 was admitted to 10/16/10 with diagr	lent had been admitted with						

PRINTED: 12/10/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (XS) DATE SURVEY COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 185250 11/24/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE, 1100 GRANDVIEW DRIVE, P O BOX 822 **OAKMONT MANOR** FLATWOODS, KY 41139 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X6) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OF LISC IDENTIFYING INFORMATION) PREFIX PRÉFIX DATE TAG DAT DEFICIENCY F 309 Continued From page 12 F 309 Emergency Room records revealed the resident complained of abdominal pain rated with a severity of eight (8) on a scale of ten (10). Review of the abdominal x-ray dated 10/16/10, revealed a "markedly large amount of stool in the rectosigmoid portion of the colon most consistent with severe constinution/impaction." Review of the Computerized Tomography (CT) scan of the abdomen dated 10/16/10 revealed severe Impaction of the rectosigmoid with stool." The hospital's History and Physical (H&P) dated 10/17/10, was reviewed and revealed the physician assessed the resident to have severe constinution. The resident was noted to have been anxious, with abdominal pain and sluggish bowel sounds. A rectal exam revealed hard stool In the rectum. At the time of dictation of the H&P. the resident had received two (2) Fleets enemas with results of two (2) moderate bowel movements. Review of the Surgical Consult dated 10/18/10 revealed Resident #1 had a "severe stool impaction." Aggressive laxative therapy was initiated. The Surgical Consult dated 10/19/10 revealed Resident #1 had a bowel-to-bladder fistule (a connection between the intestine and the bladder which allowed fecal material to spill into the bladder). In addition, the resident was

FORM CMS-2597(02-99) Previous Versions Obsolete

2009).

diagnosed with sepsis, a condition of 'destruction of tissues caused by disease-causing bacteria or their toxins" (The Bantam Medical Dictionary,

Review of the infectious Disease consult dated 10/18/10, revealed Resident #1 was assessed to have severe constitution, severe abdominal pain

Event ID: P1N611

Feoility ID: 100523

If continuation sheet Page 13 of 24

PRINTED: 12/10/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED <u>OMB NO. 0938-0391</u> CENTERS FOR MEDICARE & MEDICAID SERVICES (X8) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 165250 11/24/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1100 GRANDVIEW DRIVE, P O BOX 822 **OAKMONT MANOR** FLATWOODS, KY 41139 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X§) .(X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE REGULATORY OR LEC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 309 Continued From page 13 F 309 "worrisome for perforated bowel", and sepsis. The Operative Report dated 10/21/10 was reviewed and revealed Resident #1 underwent an Exploratory Laparotomy. Continued review revealed feculent peritonitis (inflammation due to contamination with feces) was present throughout the abdomen. Two (2) liters of purulent (pus-filled) fluid was suctioned out. A Colovesical (bowel-to-bladder) fistula was identified, with the bladder containing fecal material as well. A colectomy with colostomy was performed, the fistule was repaired, and a supra-pubic urinary catheter was placed. During interview on 11/24/10 at 4:45 PM, the attending physician for Resident #1 stated he had spoken to the surgeon, who reported the resident had a fecal impaction with perforation of the bowel. The attending physician denied having received a call from the facility related to the resident's constination or lack of bowel movements. An interview was conducted with Resident #1, on 11/23/10 at 9:30 AM, at the nursing home he/she resides at this time. During the interview the

FORM CMS-2567(02-99) Previous Versions Obsolets

realdent expressed having a long history of constipation which required the use of five (5) to six (6) Colace tablets (a stool softener) twice daily. In addition, the resident reported the use of "Fleets" suppository "at least twice a week." The resident expressed having a history on going four (4) days without a bowel movement. The resident stated, "I knew I had to stay on it, that's why I took so much Colace." Further interview revealed Resident #1 reported he/she "begged them (facility steff) every day" to get an order for a Fleet's suppository. The resident stated, "I

Event ID: P1N611

Facility ID: 100528

If continuation sheet Page 14 of 24

CENTER		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CL/A IDENTIFICATION NUMBER:	1.		•	CONSTRUCTION	• •	FORM /	
		186250	B. WING					11/24	; /2010
NAME OF P	OVIDER OR SUPPLIER					FADDRESS, OITY, STATE,		1	
OAKMON	IT MANOR					GRANDVIEW DRIVE, P (TWOODS, KY-41139	D BOX 832		,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUILL SC IDENTIFYING INFORMAT(ON)	PAEF TAG	IX		PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	OTION SHOUL OTHE APPRO	DBE	(X5) COMPLETION DATE
F 309	Continued From pa	ige 14	F	30	9				1
	begged them, they there and almost d	ignored me. They let me lay le.							. }
•	at 2:30 PM, revealed the hospital on 10/he/she had spoker Resident #1's surge bowel had burst. A surgeon further regimpacted, the bower required a colostor the spouse had spohysician, who had ever called him bowel movement. 2. Review of Residences	dent #1's spouse, on 11/23/10 ad Resident #1 was admitted to 16/10. The spouse indicated to the resident's surgeon after ery and was told the resident's according to the spouse, the corted the resident was so al was dead and the resident ny. Further interview revealed been to the resident's attending I cared for the resident at the the physician reported no one in about the resident's lack of a dent #3's clinical record s which included Dementia with		•					
	Delusions and Cor Review of the Aug Physicians Orders Lactulose (a laxati daily as needed du for Bisacody! (a lax rectally once daily Review of the Aug Tracking Log reve of a Bowel Movem days). Review of Record (MAR) rev								
		tember and October 2010 Tracking Logs revealed no					, ,		

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/10/2010 APPROVED 0938-0391				
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LULTĮPLE	CONSTRUCTION	(X3) DATE 8	URVEY				
••		185250	B. Wif	4G	**	I !	C 4/2010				
•	ROVIDER OR SUPPLIER '		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 GRANDVIEW DRIVE, P'O BOX 522 FLATWOODS, KY 41139								
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL 8C IDENTIFYING INFORMATION)	ID PAEF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS REFERENCED TO THE DEFICIENCY)	SHOULD BE	(XS). COMPLETION DATE				
F 309	described by the fa 15-October 2 (18 d and October 19-22 September and Oc	nce of adequate BMs, as cility's policy, from September ays), October 8-17 (10 days), (4 days) and review of the tober 2010 MAR revealed no noe that the prescribed	F	309		•					
•	Bowel Information documented evider October 26-Novem 8-23 (16 days). Re November MAR rev 11/04/10 and 11/06	ice any other bowel	•	1							
	Practical Nurse #1 was not followed. the Bowel Care Pro have received Lact enema several time Medication Technic logs daily, give the notify the nurse whi stated she was une regarding the Physi	10.at 10:30 PM with Licensed revealed Bowel Care protocol. The nurse stated according to otocol, Resident #3 should ulose, Dulcolax, and Flests es. LPN #1 stated the Certified items (CMT) examine the bowel Lactulose when needed and en it was given. She further able to find documentation ician being notified of the mination for Resident #3.									
	Resident #4 was as	inical record revealed imitted on 06/30/10 with cluded Ovarian Cancer and									
	Minimum Data Set	ficant Change Admission (MDS) Assessment dated ssion MDS Assessment dated				•	,				

Uakmont Iylanor PRINTED: 12/10/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CUA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER; A BUILDING B. WING 185250 11/24/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1100 GRANDVIEW DRIVE, P O BOX 822 **OAKMONT MANOR** FLATWOODS, KY 41129 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REPERENCED TO THE APPROPRIATE (X6) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREPIX DATE TAG TAG DEFICIENCY F 309 F 309 Continued From page 16 07/13/10 revealed the facility assessed the resident as having constipation. Review of the Comprehensive Plan of Care dated 09/16/10, revealed the resident was at risk for constinution due to decreased mobility and "routine" use of pain medications. The Plan of Care revealed interventions which included: administering medications as ordered, monitoring bowel movement (BM) each shift, and reporting if no BM every two (2) to three (3) days. Review of a Computed Tomography (CT) Scan report, dated 09/07/10 revealed findings which included probable constitution and fecal impaction. Review of the August, September, October, and November 2010 Monthly Physician Orders revealed orders for Fibergias (bulk-forming lexative for constination) tablet every day and Bisacodyl (laxative for constipation) 10 milligram rectal suppository every three (3) days. Continued review revealed orders for Lactulose (synthetic sugar lexative for constinution) thirty (30) milliliters by mouth every four (4) hours PRN (as needed), Bisacodyl ten (10) milligram rectal suppository every day PRN and Enema disposable Fleet type (saline laxative for constination) once dally PRN. Review of Resident #4's August, September.

October and November 2010 Bowel Information Tracking Logs revealed no documented evidence of adequate (per the facility's policy) bowel elimination from 08/13/10 through 08/19/10, seven (7) days; from 08/31/10 through 09/29/10 seven (7) days; 09/23/10 through 09/29/10 seven (7) days; 09/30/10 through 10/06/10, seven (7)

Jan.	4. 2011 1:19	THE CARMONIC MANOR				IN	0.7400		
		AND HUMAN SERVICES					PRINTED: 12/10/2010 FORM APPROVED		
		& MEDICAID SERVICES	1.) <u>, 0938-0391</u>	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILO		CONSTRUCTIO	·N	(X3) DATE S COMPL		
		185250	B. WING	3		C 11/24/2010			
NAME OF P	ROVIDER OR SUPPLIER		1	STREET	ADDRESS, CIT	Y, STATE, ZIP COD			
	NO MANOR		, ⁻	1100,		DRIVE, P.O BOX			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDI (EACH CO	ER'S PLAN OF COR RECTIVE ACTION : ERENCED TO THE A DEFICIENCY)	SHOULD BE	(XS) COMPLETION DATE	
F 309	Commission Total po	ige 17 through 11/02/10, seven (7)	F 30	09	•				
	no documented evi the Bowel Care Pro of as needed bowe	ient's medical record revealed dence the facility implemented blocol, including administration if medications, or notification of clan when the resident did not well movements.							
,		dent #7's clinical record s which included Osteoarthritis, and Bilateral Knee						,	
	Assessment dated assessed Resident impairment in cogn extensive assistant Living. Further rev	ual Minimum Data Set (MDS) 04/16/10, revealed the facility t #7 as having moderate ittive skills and requiring se with most Activities of Dally few of the resident's MDS led the facility assessed the no constipation.							
	10/15/10 revealed Bowel Elimination The Interventions i medication as orde	prehensive Plan of Care dated the resident had Impaired with Occasional Constipation. notuded; administering ered; monitoring bowel ach shift, and reporting if no BM ee (3) days.					•		
	Monthly Physician Lactulose (a laxath mouth as needed f	ober and November 2010 Orders revealed orders for one of twenty (20) milliliters by for constipation and Bisacodyl rectal suppository once a day of the order.					: '		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/10/2010 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUI A. BUILL	iltiplė construction Ding	(XS) DATE SURVEY COMPLETED C		
		165250	B. WING	G		/ 1/2010
	ROVIDER OR SUPPLIER VT MANOR		Ę	BTREET ADDRESS, CITY, STATE, ZIP CODE 1100 GRANDVIEW DRIVE, P O BOX 8 FLATWOODS, KY 41199		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REQUILATORY OR LSC IDENTIFYING INFORMATION)				PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X8) COMPLETION DATE
F 309 S9≃G	November 2010 B Logs revealed no d adequate (as noted élimination from 10 (5) days; 10/16/10 through 1 11/08/10 through 1 11/08/10 through 1 11/17/10 through 1 Review of the resident documented ev Bowel Care Protoco the facility failed to to administering as ordered and report movement every the service with LPN revealed if a resident movement in three should be initiated count a small bowe most residents. Si should be notified implementing the interview revealed administering the indocumented on the 483.75(o)(1) QAA COMMITTEE-MEI QUARTERLY/PLA A facility must mai assurance commit	t #7's October 2010 and owel Information Tracking lacumented evidence of tin in the facility's policy) bowel 1/10/10 through 10/14/10, five through 10/19/10, four (4) ough 10/26/10, six (6) days; 1/03/10 seven (7) days; 1/10/10, five (5) days; and 1/21/10, five (5) days; and 1/21/10, five (5) days. Itent's medical record revealed idence the facility followed the follow the Plan of Care related in needed (PRN) medications as ling if the resident had no bowel to (2) to three (3) days. #2 on 11/24/10 at 11:20 AM ent did not have a bowel to (3) days, the Bowel Protocol is the stated she would not be movement as adequate for the further stated the physician if there were no results after cowel protocol. Continued all PRN medications results obtained after medications, should be the MAR. MBERS/MEET INS	F 30	It is and was on the day of the policy at Oakmont Ma to maintain a Quality Ass Committee that identifies and develops and implem of action to correct quality	nor urance s issues ents plans	
F 520 99=G	administered, and administering the redocumented on the 483.75(o)(1) QAA COMMITTEE-MEI QUARTERLY/PLA A facility must mai assurance commit	results obtained after medications, should be e MAR. MBERS/MEET NS ntain a quality assessment and	F 5	the policy at Oakmont Ma to maintain a Quality Ass Committee that identifies and develops and implem	nor urance s issues ents plans	

		AND HUMAN SERVICES & MEDICAID SERVICES	,			FORM	: 12/10/2010 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES: (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		185250	B. WIN	KO	1.	11/9	C 4/2010
	ROVIDER OR SUPPLIER			110	EET ADDRESS, CITY, STATE, ZIP CODE 00 GRANDVIEW DRIVE, P O BOX 82 .ATWOODS, KY 41189		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			X.	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS REFERENCED TO THE APP DEFICIENCY)	OULD BE .	(X6) COMPLETION DATE
F 520	facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.		F	620	1. Resident #1 no longer resident #3, #7 medical records have be reviewed and have bowel pestablished. This was compon November 29, 2010 by the Unit Coordinator. 2. All other residents medic records have been reviewed to ensure a bowel pattern been established and to determine MD notification occured. This was completed on November 2 by the QA nurse.	#4, and een patterns leted cal ed has	
	by: Based on interview determined the facilito implement the facilito implement the facility cand #7). Residents have adequate bow facility policy, for petwenty (20) days. Facility falled to folioregarding the adminolification of physicommittee had not	and record review it was lity failed to identify the failure cility's Bowel Care Protocol to et movements for four (4) of sidents (Residents #1, #3, #4 #1, #3, #4, and #7 did not rel movements, as defined per riods ranging from four (4) to lacord review revealed the witheir Bowel Care Protocol histration of medications and cians. The Quality Assurance identified the system failure, discorded to correct			3. All licensed staff have be educated by the Director of Nursing on December 6 th of The Bowel Program and Notification of Changes to Physician. Audits are being complete daily by the Director of Nuand/or QA nurse to determinely Notification of Phyaudits are being complete Mondays and Thursdays book of the QA nurse to assure that all residents have had an ade	of on orsing nine sician. d on y the	

bowel movement in three days.

		AND HUMAN SERVICES		•		D: 12/10/2010 VI APPROVED	
•		& MEDICAID SERVICES				D: 093B-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDING	PLE CONSTRUCTION .	(X8) DATE (COMPI	(X3) DATE BURVEY COMPLETED		
185250		B. WING _	******	C 11/24/2010			
NAME OF PROVIDER OR SUPPLIER OAKMONT MANOR			· 11	EET ADDRESS, CITY, STATE, ZIP CODI 100 GRANDVIEW DRIVE, P O BOX (LATWOODS, KY 41199	5 922		
(X4) ID PREFIX TAG	EAOH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	PREFOX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(XS) COMPLETION DATE	
F 520	failure to implement notify the resident's of bowel movement resident was admitt constipation and fedunder surgical intercolostomy. The findings include Review of the facility (undated) revealed one (1) large or two movements every thadequate. 1. Resident #1 was 09/24/10. Review of Logs for September revealed no evident movement for elevent 10/04/10. The track had a medium bower movement or application of the Belogs revealed the readequate bowel movement for on 09/24/10 to 10 evidence the physic resident's tack of both resident's tack of the part of	espitalized on 10/16/10, after the Bowel Care Protocol, or physician regarding the lack a by the resident. The ed with diagnoses including pal impaction. The resident evention and placement of a seriod a resident must have at least (2) medium bowel area (3) days to be considered admitted to the facility on a Bowel Information Tracking and October of 2010 and Octob	F 520	As part of the facility's on Quality assurance progra Director of Nursing will redaily shift reports and nu documentation to ensure change of status has been reported to the physician. 4. The Quality Assurance Committee met on Decer 13th to review the results aforementioned audits and determine compliance. All licensed nursing staff been in-serviced on physician notification on December DON. The quality assurance committee will meet more for the next six months for any changes in resider conditions. The daily audit conducted by the DON with summarized and reported during the aforemention meeting.	m the eview rsing all and a sician of the and to a sician of the additional and the addi	er 14, 2010	
	abdominal x-ray dat Computerized Tomo	ecords, including an ed 10/16/10, and a graphy (CT) scan, dated Resident #1 had a large					

NO. /400

		AND HUMAN SERVICES & MEDICAID SERVICES		•	PRINTED: 12/10/2010 FORM APPROVED OMB NO: 0938-0391			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185250		(X2) MULTI A. BUILDIN	IFLE CONSTRUCTION	(X8) DATE 8 COMPLI	néo			
		B. WING _		• }	C 4/2010			
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STĂTE, ZIP CO	•	•		
OAKMON	IT MANOR			1100 GRANDVIEW DRIVE, P O 80: FLATWOODS, KY 41139	K 822			
(X4) ID PAEPIX DAT	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENT(FYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CHOSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X6) COMPLETION DATE		
F 520	Continued From pa	ge 21	F 520					
	colon, consistent w	he rectosigmoid portion of the ith fecal impaction. In accords indicated the resident intervention, with placement			٠.	,		
•	of a colostomy on 1				. ,			
,	05/18/09. Review of record revealed no adequate bowel mo Bowel Care Protoco October 2 (18 days October 18-22 (4 dithere was no evide	admitted to the facility on of the resident's medical documented evidence of an overnent, per the facility's oi, from September 15 -), October 8-17 (10 days), and ays). During November, 2010, noe of an adequate bowel						
	(11 days), and Novidays). Review of Cotober of 2010 re- evidence the Bowe with interventions in bowel movements.	n October 26 and November 6 sember 8 and November 23 (16 the MAR for September and vealed no documented I Care Protocol was followed in addition, there was no cian was notified related to the atus.						
	admitted to the fact Resident #4's med documented evidel elimination from 08'd (5) days; from 08'd days, 09/23/10 thro 10/01/10 through 1 10/28/10 through 1 was no evidence the Care Protocol, inches to ensure regular by	evealed Resident #4 was lity on 06/30/10. Review of ical record revealed no nice of adequate bowel 1/13/10 through 08/19/10, six (6) bugh 09/29/10, seven (7) days; 0/06/10, six (6) days; and 1/02/10, six (6) days. There he facility followed the Bowel uding medication administered lowel movents, nor notification lysician regarding the lack of						

Jan.	4. 2011 1:20	PM Dakmont Manor								WO.	/480	٠٢.	21	
DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES											F	MRO	12/10/ APPRO 0938-	DVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING					·	(XS) DATE SURVEY COMPLETED						
I		185250	B, WIR	NG.	 _	~~~~~	,		<u>.</u>			•	0 1/2010	, [
NAME OF PROVIDER OR SUPPLIER OAKMONT MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 GRANDVIEW DRIVE, P O BOX 822 FLATWOODS, KY 41139											
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC [DENTIFYING INFORMATION]	ID PREF TAG	X		(EAC)	H CORI	rectivi Rencei	E ACTIO	XORREC ON SHOU HE APPR	ULD BE	re	COMPU COMPU	
F 520	admitted to the factoresident's medical documented evider elimination from 10 (5) days; 10/16/10 through; 10/28/10 through 1 11/06/10 through 1 11/06/10 through 1 11/17/10 through 1 was no evidence fallowel. Care Protoc Interview with the L#1, #3, and #7 resirevealed in addition Tracking Log, the form she referred to stated she reviewed times a week, on Mind Fridays, but had not the Bowel Care Profurther stated this kinct part of the med Bowel Log as a con Certified Medical Transes.	avealed Resident #7 was ality on 09/28/04. Review of the record revealed no once of adequate bowel 0/10/10 through 10/14/10, five through 10/19/10, four (4) ough 10/26/10, six (6) days; 1/03/10, seven (7) days; 1/10/10, five (5) days; and 1/21/10, five (5) days, there acility staff implemented the col for Resident #7. Unit Manager where Residents ide, on 11/24/10 at 11:55 AM, in to the Bowel Information acility utilized an additional to as the Bowel Log. She ad the Bowel Log three (3) Mondays, Wednesdays, and ox identified any concerns with otocol implementation. She og was an internal record and lical record. She described the mmunication tool between the fechnicians (CMTs) and the	F !	520	20									
	revealed she consi movement in three Upon reviewing the UM, she stated she medium bowel mov the facility's protocol	w with the Unit Manager (UM) idered one (1) medium bowel (3) days to be adequate. Bowel Care Protocol with the had not been aware one (1) vement was not adequate, per oi. The UM was unaware of had an adequate bowel inty (20) days.									•			

Interview with the CQI/QA Coordinator on

	and the second s	& MEDICAID SERVICES		ı			APPROVED <u>0938-0391</u>	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) A. BU		IPLE CONSTRUCTION	C 11/24/2010			
185250			B. Wi	NG_				•
'	ROVIDER OR SUPPLIER VT MANOR			1	REET ADDRESS, CITY, STATE, ZIP CODE 1100 GRANDVIEW DRIVE, P O BOX 622 FLATWOODS, KY 41139		•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECECED BY FULL SC IDENTIFYING INFORMATION)	PREF TAX	FIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUND FOR THE APPROPRIEM OF THE		COMPLETION DATE	
F 520	met monthly to devine problems. She state to check the progressince the introduction 3.0 Version on 10/0 identify triggered are Committee. Continuates on the matrix were reviewed by the Coordinator explains.	M, revealed the committee elop action plans for identified the weekly meetings were held iss of the plan. She explained on of the Minimum Data Set 17/10, the matrix was used to leas for follow-up by the QA used interview revealed any that fell in the 75th percentile he committee. The CQI/QA and that bowel management or further review, and was not	F	520				
			,					

, NO. 7400 I. ZO

PRINTED: 12/10/2010